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**How to Prepare for ICD-10/5010 to Reduce F41.1 (Anxiety Reaction)**

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**How to Prepare for ICD-10/5010 to Reduce F41.1 (Anxiety Reaction)**

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**Today's Program**

- **Introduction**
- **Presentation:**  
Nancy Maguire, ACS, PCS, FCS, HCS-D, CRT
- **Kareo Special Offer:**  
Rick Palmer, Account Executive, Kareo
- **Questions**

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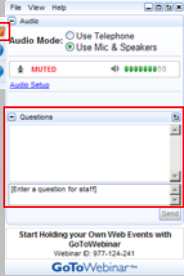
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### How to Participate Today



- Arrow = Open/close your panel
- Questions = Submit text questions

Follow-up email with video link within 24 hours

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### How to Prepare for ICD-10/5010 to Reduce F41.1 (Anxiety Reaction)

Nancy Maguire, ACS, PCS, FCS, HCS-D, CRT



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### The Final Rule

- Published on January 16, 2009  
<http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>
- The Final Rule allows for the use of the updated 5010 transactions prior to the compliance date (January 1, 2012) to facilitate the transition to the updated transactions and prevent the need to convert overnight
- You **cannot use the ICD-10 diagnosis codes on your claim forms** until October 1, 2013 or after, but to do so electronic standards 5010 must be in place and tested

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### HIPAA Transaction Set

- HHS is adopting X12 Version 5010 and NCPDP Version D.0 for HIPAA transactions
- In this rule, HHS also adopts a new standard for Medicaid subrogation for pharmacy claims, known as NCPDP Version 3.0

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### HIPAA Transaction Set (Cont'd.)

- For Version 5010 and Version D.0, the compliance date for all covered entities is January 1, 2012
  - This gives the industry enough time to test the standards internally, to ensure that systems have been appropriately updated, and then to test between trading partners before the compliance date
- The compliance date for the Medicaid subrogation standard (3.0) is also January 1, 2012, except for small health plans, which will have until January 1, 2013 to come into compliance

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### Definitions

- Version 5010 - the new version of the X12 standards for HIPAA transactions
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation
- These versions are required by the modifications made to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in January 2009

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**Information Upgrade**

- Transactions are electronic exchanges involving the transfer of information between two parties for specific purposes
- For example, a health care provider will send a claim to a health plan to request payment for medical services
- The Health Insurance Portability & Accountability Act of 1996 (HIPAA) named certain types of organizations as covered entities, including health plans, health care clearinghouses, and certain health care providers

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**Information Upgrade (Cont'd.)**

- HIPAA also adopted certain **standard transactions** for Electronic Data Interchange (EDI) of health care data
  - These transactions are: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, and premium payment
- Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard
  - This means that they must adhere to the content and format requirements of each standard

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**Why 5010?**

- Significant transaction improvements in Version 5010
- Added, improved, or removed both business functions and content
- More clarity in provider loops (blocks of repeating data)
- **Support for ICD-10 was added in upgrade to 5010**
- Clarifies NPI instructions in 5010

After the deadline on January 1, 2012, Medicare, Medicaid, and other health plans will not accept electronic transactions that are not in the 5010 format

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### Enhanced Transaction Set

- **270-271 - Eligibility**
  - Requires eligibility responses to include all subscriber/dependent National Provider Identifier (NPI) data elements that the payer would require on subsequent transactions
  - Requires alternate search options using member identifier and date of birth or member identifier and name
  - Adds new service type codes
  - Identifies primary and secondary insurance, enabling correct billing to the correct carrier

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### Plan of Action: "Who?"

- Project leader or Steering Committee
  - Key players
- Software development and revisions
- Vendor support needs
- Gap analysis - inventory of all software applications used in the organization/practice
  - Internal hardware and software
  - Business process changes (ex, charge documents)

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### Plan of Action: "Who?" (Cont'd.)

- Internal Testing – 5010 (2010)
- **External testing – 5010 (2011)**
  - Revisions based on testing
- Transition to new standards - January 1, 2012 - mandatory
- Full compliance
- Implementation and monitoring

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**Stages of Planning**

- Practice analysis
- Where are you today?
- Where will you be on January 1, 2012?
- Where will you be on October 1, 2013?

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**Stages of Planning (Cont'd.)**

- How do you get to full compliance:
  - **5010 – January 1, 2012**
    - Internal review and process analysis to upgrade to 5010
      - System review and needs
    - Budget, costs, resources before they are needed
    - Management and physician buy-in—Communicate
    - Assemble team with responsibilities and accountability, include physician(s)
    - Follow CMS website for directions  
[http://www.cms.gov/Versions5010andD0/01\\_overview.asp#TopOfPage](http://www.cms.gov/Versions5010andD0/01_overview.asp#TopOfPage)
    - External testing – partners, clearinghouses, payers (2011), **NOW**
    - Assess and monitor
  - **No Compliance—No Revenue**

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**Upgrade to 5010**

- Recommendations for HIPAA 5010 compliance:
  - Educate yourself and your office staff on the HIPAA 5010 compliance requirements by visiting the CMS website often during transition
  - Contact your Clearinghouse and payers and begin conversations about requirements, changes, and impacts of HIPAA 5010 transition
    - Ask your vendors such as practice management systems, clinical systems, and billing systems for their plan on converting to a HIPAA 5010 compliant version of your software, and any associated costs, if applicable
- **Don't wait until the last minute to identify your organization's needs for HIPAA 5010!**

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**ICD-10-CM Diagnosis Codes**

- **ICD-10-CM Codes - October 1, 2013**
  - Education early 2013 (who, what, when, where)
  - Pertinent to your practice specialty
  - Everyone should be required to read the Official Guidelines (Draft Manual)

<http://www.cdc.gov/nchs/icd/icd10cm.htm#10update>

- Communicate each step of the process
- Have the Draft manual on hand for practice exercises
- Educate physicians on code descriptions and documentation requirements; ICD-10 will increase documentation time spent in detail needed for ICD-10 codes
  - Appointment schedules must consider this time increase

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**Change on the Horizon**

- ICD-10-CM (diagnosis codes) and ICD-10-PCS (procedure codes) will replace the ICD-9 code set implemented in 1977 by the World Health Organization
- ICD-10-CM has an effective date of October 1, 2013, and is expected to be implemented by physicians, hospitals and other health care providers to identify diagnoses for documentation, medical records and claims

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**Diagnosis Codes**

- The maximum number of diagnosis codes that can be reported on a claim was increased from eight to twelve
- Although twelve diagnosis codes can be reported at the claim level, only four codes can be pointed to, or linked to, a specific service at the service line level
- So if a patient has twelve diagnoses and you perform a service that relates to five diagnoses, you can only point to four of them when billing for that service line

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### ICD-10-CM Diagnosis Code Set

- ICD-10-CM diagnosis codes - 3 to 7 characters
  - 21 Chapters
  - 5X more codes (approx. 17,000 - 68,000)
  - Laterality
  - 7<sup>th</sup> character requirement (M, O, R, S, T, VWXY)
  - V codes will become Z codes (Chapter 21)
  - E codes will become VWXY codes (Chapter 20) - secondary codes

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### Alphanumeric Codes

- There will be 3-7 characters to describe your condition(s), injuries, signs and symptoms
- The first character will be a letter (the letter U is not used but reserved for future application)
- The second character will be a number
- Characters 3-7 will be an alpha or a number
  - **S91.142A Puncture wound with foreign body of left great toe without damage to nail**
- The decimal is placed after the first 3 characters
- Dummy place-holders (X) will be placed when a code requires a 7th character but has no 4th, 5th and/or 6th character (Fall from sidewalk curb, initial encounter, code W10.1xxA) or (Fall from ladder, initial encounter, code W11.xxxA)

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### Format

- Specificity - S72.044G = **Non-displaced** fracture of base of **neck** of **right femur**, **subsequent encounter** for **closed fracture** with **delayed healing**
- Laterality (which side) - example, malignant neoplasm of **lower outer quadrant** of **right** female breast = C50.511
- "Hypertension" code I10 includes essential primary hypertension (arterial, benign, essential, malignant, primary, systemic), this is a change from ICD-9-CM where there was a separate code for benign, malignant or unspecified
- For "late effect" look under "Sequela" in Index
- External causes will be classified to V, W, X, and Y codes (secondary codes only)

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### ICD-10-CM Diagnosis Codes

- Fatigue fracture of vertebra, lumbar region, **subsequent encounter for fracture with delayed healing** = M48.46xG
  - **M48** = category
  - **46x** = etiology, anatomic site, severity
  - **G** = extension
- Epigastric abdominal tenderness = R10.816
- Puncture wound with foreign body of right cheek and temporomandibular area = S01.441A (**initial encounter**)
- Type 2 Diabetes Mellitus with diabetic neuropathic arthropathy (Charcots' joints) = E11.610

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### General Equivalence Mappings (GEM)

- Developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (**ICD-9-CM**) codes to **International Classification of Diseases, 10th Edition (ICD-10)** and the conversion of **ICD-10 codes back to ICD-9-CM**
- The GEMs are forward and **backward mappings** between the ICD-9-CM and ICD-10 coding systems and are also referred to as crosswalks since they provide important information linking codes of one system with codes in the other system

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### General Equivalence Mappings (GEM)

- One ICD-9-CM code often translates to several ICD-10-CM or ICD-10-PCS codes because of the nature of going from the more general ICD-9-CM to the more specific ICD-10
- The GEMs were developed over a period of three years by CMS and CDC, with input from both AHA and AHIMA

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### GEMS Crosswalk Example

ICD-9-CM Code	ICD-10 Crosswalk
250.00	E11.9
250.01	E10.9
250.02	E11.9
250.03	E10.9

250.02 – uncontrolled, Type II  
250.03 – uncontrolled Type I

There is no “controlled” vs. “uncontrolled” in ICD-10-CM

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### Excludes Notes

- **Excludes 1** indicates **not coded here**.
- The code being excluded is **never used with the code**.
- The two conditions **cannot occur together**.
- For example, S01.05xA “Open bite of scalp, initial encounter”:
  - **Excludes 1** superficial bite of scalp (S00.06, S00.07-)

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### Excludes 2 Note

- **Excludes 2** indicates not included here
- The excluded condition is **not part of the condition represented by the code**
- It is acceptable to use both codes together if the patient has both conditions
- For example, T20.511A, “Corrosion of first degree of right ear [any part except ear drum], initial encounter”
  - **Excludes 2 – corrosion of ear drum (T28.91-)**

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### CPT and HCPCS

- CPT and HCPCS, which are used for all ambulatory and physician procedure reporting, **are not being replaced by ICD-10**
- **Volume 3 of ICD-9-CM is being replaced by PCS (inpatient procedures)**

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### ICD-10-PCS Hospital Inpatient Procedures

- Alphanumeric procedure classification system used for **inpatient hospital** settings only
- Uses seven characters, alpha or numeric, **excluding the letters I and O** to avoid confusion with numbers 1 and 0

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### ICD-10-PCS Hospital Inpatient Procedures (Cont'd.)

- Characters in the medical and surgical section carry the following meaning, in order:
  - **section, (ex, surgical)**
  - **body system, (ex, Integumentary)**
  - **root operation, (ex, suture, repair)**
  - body part, (ex, left lower arm)
  - approach, (ex, open or non-invasive)
  - device, (ex, laparoscope), and
  - Qualifier (ex, diagnostic or Z)
- Inpatient procedure code for suture of skin laceration, left lower arm = **0HQEXZZ**
- ICD-9-CM Vol. 3      3,824 codes
- **ICD-10-PCS      72,589 codes**

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**Foundation**

- Start with learning the process
- Build a strong foundation
- Be aware of the differences involved with ICD-10 codes
- Physician education is critical, codes are assigned if supported by medical record documentation
- Practice exercises using ICD-10 codes instead of ICD-9 diagnosis codes

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**Impact**

- This is a substantial transition from ICD-9 to ICD-10
- Physician documentation workload will increase and continue; this is not temporary
- Both ICD-9-CM and ICD-10-CM codes will be in play for some time based on date of service on claim form
- Physician practices will use only ICD-10-CM. They will not use ICD-10-PCS, the procedure coding system
- The number of codes increases from about 13,000 to 68,000 (ICD-10)

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**Prepare and Prevent Damage Control**

- Positive attitude
- Consider it like learning a new language
- The increased specificity in ICD-10-CM means that codes are easier to assign correctly, because there are fewer ambiguities
- Assigning codes directly from the documentation is viewed as the best practice and will reduce errors
- Change happens, but with it - opportunities!!

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